



Department
for Education

Review of the role and functions of Local Safeguarding Children Boards

**The government's response to Alan
Wood CBE**

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Contents

Review of the role and functions of Local Safeguarding Children Boards	3
Foreword	3
The Government's response	4
Introduction	4
Local Safeguarding Children Boards	5
Serious Case Reviews	7
Child Death Overview Panels	8
Conclusion	8

Review of the role and functions of Local Safeguarding Children Boards

Foreword from the Secretary of State and the Minister of State for Children and Families

Local agencies are the front line when it comes to safeguarding our children and it is vitally important that they work well together. That is why we asked Alan Wood to undertake a review of Local Safeguarding Children Boards. Alan's wide experience in the sector has been invaluable in this review.

We are grateful to Alan for his hard work and for the thorough and insightful approach he has brought to it. We are also grateful to the many individuals and organisations who have contributed. There was an impressive response to the consultation for this review, meaning that the report significantly deepens our understanding of how local multi-agency arrangements for safeguarding children are currently operating. This leaves us in a strong position to make the right decisions about how the system can be improved for the future.

We want strong and effective arrangements for local agencies to work together to improve outcomes for children and their families and share information effectively. Alan's review has set us on the right road to enable local areas to build on the best of what already exists and to think innovatively about how wider improvements can be made. This document sets out the government's response and what we intend to do to strengthen multi-agency working and improve practice at local and national level.

The Government's response

Introduction

1. Nothing is more important than promoting the welfare of children and protecting them from harm. Our goal is to support and enable local agencies to work together in a system where:

- Excellent practice is the norm;
- Partner agencies hold one other to account effectively;
- There is early identification of 'new' safeguarding issues;
- Learning is promoted and embedded;
- Information is shared effectively;
- The public can feel confident that children are protected from harm.

2. The Prime Minister announced on 14 December 2015 that ministers had asked Alan Wood CBE to undertake a fundamental review of the role and functions of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working. This included consideration of the child death review process, and how the intended centralisation of serious case reviews (SCRs) would work effectively at local level.

3. The next sections set out our response to the Wood Review, what the proposed new arrangements will look like, and how we will implement them.

Local Safeguarding Children Boards

4. The Wood Review argues that strong, effective multi-agency arrangements are ones that are responsive to local circumstances and fully engage the right people.

5. The review found widespread agreement that the current system needs to change in favour of a new model that will ensure collective accountability across the system. This is the view that has emerged from extensive consultation with a wide range of individuals and organisations and with independent experts such as Lord Laming and Baroness Jay.

6. We agree with that. Current arrangements are inflexible and too often ineffective. Meetings take place involving large numbers of people, but decision-making leading to effective action on the ground can be all too often lacking.

7. We will introduce a stronger but more flexible statutory framework that will support local partners to work together more effectively to protect and safeguard children and young people, embedding improved multi-agency behaviours and practices. This framework will set out clear requirements for the key local partners, while allowing them freedom to determine how they organise themselves to meet those requirements and improve outcomes for children locally.

- **To ensure engagement of the key partners in a better coordinated, more consistent framework for protecting children, we will:**

Place a new requirement on three key partners, namely local authorities, the police and the health service, to make arrangements for working together in a local area. This would not change the existing statutory functions or duties on any of the agencies individually, but it will require more robust and much clearer arrangements to promote effective joint working, in relation to safeguarding and promoting the welfare of children.

- **To ensure these arrangements are multi-agency in their approach, we will:**

In addition to the new duty on the three key agencies, place an expectation on schools and other relevant agencies involved in the protection of children, to co-operate with the new multi-agency arrangements.

The leaders from the three key sectors will be able to call on the support and co-operation of partner agencies, to form a clearer picture of how agencies are performing, and to make evidence-based decisions on how to achieve the best possible outcomes for children.

- **To simplify and strengthen the existing statutory framework around multi-agency working, we will:**

Remove the requirement for local areas to have LSCBs with set memberships, often leading to large and unwieldy boards. Local areas that have strong and effective arrangements for multi-agency co-operation delivered through their LSCB will be able to retain them as long as they meet the new requirements. That means that the three key partners will take the decision to continue the arrangements because they see this as the most effective form of securing coordination. However they will be able to take advantage of much greater flexibility in developing arrangements that respond to local need and in which agencies are better invested. That flexibility will enable joint identification of and response to existing and emerging needs and priorities and improve outcomes for children.

- **To ensure that local areas have robust arrangements in place for how the key sectors will work together, we will:**

Bring forward legislation to underpin the new arrangements. We will support this with statutory guidance and we will work with the inspectorates to establish suitable review arrangements.

Require the three key sectors to establish governance arrangements and decide a range of issues, including the following:

- The area or region which should be covered under the joint arrangements;
- How they will involve and work with other agencies who have a key role in protecting children;
- A plan setting out details of the arrangements, which they will publish;
- Resourcing for the arrangements;
- How they will ensure a strong degree of independent scrutiny of the arrangements.

- **In cases where local arrangements do not work effectively, we will:**

Provide for the Secretary of State to have power to intervene in situations where the three key agencies cannot reach an agreement on how they will work together, or where arrangements are otherwise seriously inadequate.

Serious Case Reviews

8. The Wood Review argues that we need a fundamental change, bringing to an end the existing system of serious case reviews, and replacing it with a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm.

9. The review sees the essential components of the new framework as:

- high quality, published, rapid local learning inquiries;
- the collection and dissemination of local lessons;
- the capacity to commission and carry out national serious case inquiries;
- a requirement to report to the Secretary of State on issues for government derived from local and national inquiries.

10. We agree. We therefore intend to:

- **Replace the current system of SCRs and miscellaneous local reviews with a system of national and local reviews in order to:**
 - bring greater consistency to public reviews of child protection failures;
 - improve the speed and quality of reviews, at local and national levels, including through accrediting authors;
 - make sure that reviews which are commissioned are proportionate to the circumstances of the case they are investigating;
 - capture and disseminate lessons more effectively, at local and national levels;
 - make sure lessons inform practice.
- **In order to make a centralised system work effectively, we will legislate to:**
 - establish an independent National Panel which would be responsible for commissioning and publishing national reviews and investigate the most serious and/or complex cases relating to children in circumstances which the Panel considers will lead to national learning;
 - require Local Safeguarding Children Boards (and their successor arrangements) to carry out and publish the lessons from local reviews into cases which relate to a child or children in the local area and which are likely to lead (at least) to local learning.

11. We will use the planned What Works Centre for children's social care to analyse and disseminate lessons from both local and national reviews. Up to £20m has been announced by the Government in the latest spending review, to fund both the What Works Centre and the centralisation of SCRs.

Child Death Overview Panels

12. The Wood Review found that the gathering and analysis of data on child deaths is incomplete and inconsistent, leading to a gap in our knowledge. It suggests that child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. It also suggests that regionalisation should be encouraged and that consideration should be given to establishing a national-regional model for child death overview panels (CDOPs).

13. The review argues that child death reviews should continue to be hosted within local multi-agency arrangements but CDOPs should be hosted within the NHS, and that ownership of the arrangements for supporting CDOPs should move from the Department for Education to the Department of Health.

14. We agree with that. Evidence suggests that over 80% of child deaths have medical or public health causation and that only 4% of child deaths relate to safeguarding.

15. Therefore we intend to:

- Put in place arrangements to transfer national oversight of CDOPs from the Department for Education to the Department of Health, whilst ensuring that the keen focus on distilling and embedding learning is maintained within the necessary child protection agencies

Conclusion

16. This is the beginning of a time of considerable change. It is essential that partners continue to work together in LSCBs as we take forward the work to make that change happen. We know that there is good practice in the system and the review has shown that there is much openness to change. The new arrangements will enable good practice to continue and improve further, as well as support deeper and longer-term reform.



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